Todd P. Briscoe, D.D.S., P.C.
7833 Saint Joe Center Road
Fort Wayne, IN 46835
Ph: (260) 486-9950 Fax: (260) 485-1651
www.briscoedentistry.com

Child's Medical History

Date: _____

Child's Name: _____ Date of Birth: _____

Parent's Name: _____ _____

Child's Physician: _____ Address: _____

Phone: _____ Date of Last Physical Exam: _____ Results: _____

yes/no

Y/N Is child under care of physician now?

_____

Y/N Is child receiving any medication?

_____

Y/N Is there excessive bleeding when cut?

_____

Y/N Is there any allergy to other drugs?

_____

Y/N Has the child ever had surgery?

_____

_____

yes/no

Y/N Does child have good physical coordination?

_____

Y/N Are there any emotional problems?

_____

Y/N Is there any allergy to penicillin?

_____

Y/N Has the child ever been hospitalized?

_____

Y/N Does the child have any other allergies: food

Latex, pollen, animals, dust, other?

_____

Has the child had any history of, or difficulty with, any of the following?

Y/N	Anemia	Y/N	Bladder	Y/N	Epilepsy	Y/N	Liver	Y/N	Rheumatic Fever
Y/N	Acquired Immune Deficiency Syndrome	Y/N	Cerebral Palsy	Y/N	Fainting	Y/N	Malignancies	Y/N	Thyroid
Y/N	Asthma	Y/N	Chronic Sinus	Y/N	Heart	Y/N	Measles	Y/N	Venereal Disease
Y/N	AIDS Related Complex	Y/N	Convulsions	Y/N	HIV	Y/N	Kidney	Y/N	Mononucleosis
Y/N	Diabetes	Y/N	Mumps	Y/N	Other				

Please describe any current medical treatment **including** drugs, pending surgery, recent injuries or any other information Dr. Briscoe should be aware of that has not been discussed.

_____

_____**(OVER)**

May we request release of your child's medical records for our reference? **Yes/No**

This information was discussed with and provided by _____
Your Name

Your relation to the child is: _____

I certify the above is true and correct to the best of my knowledge.

Signature: _____ Date: _____
Parent or Guardian

Minor Child Treatment Release

I give my permission to Todd P. Briscoe, DDS, PC and/or his designated employee(s) to perform any and all dental techniques and procedures, including, but not limited to, the administration of nitrous oxide sedation and anesthetics on my child(ren) (please print each child's name :

_____, _____, _____,
_____, _____, whether or not I am present at the actual appointment when the treatment is rendered. I further expressly agree to be financially responsible* for all treatment rendered to the above named child(ren).

Signed:_____ Date:_____

Relationship to Child(ren):_____

*Please refer to the Financial Responsibility form as this is applicable to all family members.